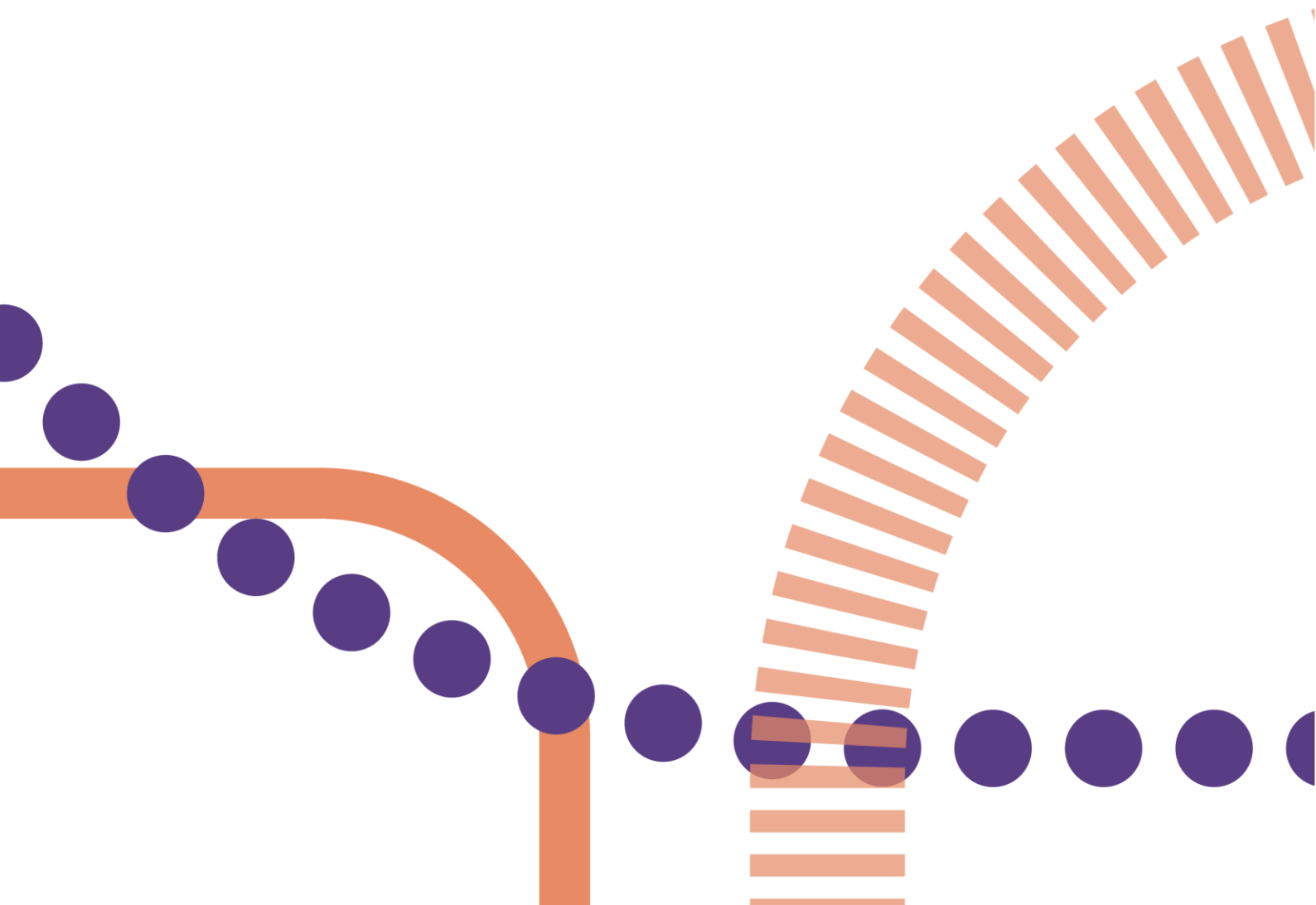
THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Preparing for a Public Inquiry

July 2026



Introduction

A public inquiry is an investigation set up by the Government to respond to events of major public concern or to consider controversial public policy issues.

On occasions, those involved with high-profile and complex child safeguarding incidents may become involved with inquiries. This briefing aims to help when that rare situation occurs.

The Child Safeguarding Practice Review Panel would expect to offer support and expertise to any safeguarding partnership involved with a relevant public inquiry. This might include giving advice on whether it is sensible to pause an LCSPR while an inquiry takes place or by making introductions to other partnerships who have managed similar situations in the past.

Who is this document for?

Safeguarding partnerships and all those working in multi-agency contexts, from frontline staff to senior leaders.

Understanding inquiries

In situations involving high levels of public concern and controversy, a public inquiry may be established to understand what has happened in those circumstances and what can be learned to prevent them recurring in the future. At the end of the inquiry, recommendations are made for future action.

Notable inquiries relating to child protection include the Victoria Climbié Inquiry, the Southport Inquiry, the Independent Inquiry into Child Sexual Abuse and, more recently, the Statutory Independent Inquiry into Grooming Gangs which formally began on 31st March 2026. At the time of writing, there are also high-profile inquiries (not relating to child protection) taking place into the response to the COVID-19 pandemic and into the murder of Sarah Everard by a serving police officer.

Types of inquiry

Inquiries can be **statutory** or non-**statutory**.

Statutory inquiries

Statutory inquiries are usually governed by the Inquiries Act 2005 (“the Act”) and the Inquiry Rules 2006 (“the Rules”). This legislation provides statutory inquiries with specific powers (beyond those available in non-statutory inquiries), including the power to compel witnesses to give evidence – which might be through written witness statements and/or attendance to give oral evidence at a hearing. Statutory inquiries operate within the framework set by the Act and can therefore at times appear more formal or procedural. These inquiries are often chaired by a senior and independent figure – frequently a

member of the judiciary, but sometimes another experienced professional – and, by their nature, the oral hearings can feel similar to giving evidence in court. Legal representatives are typically present, and witnesses may be questioned in a structured and controlled manner. However, unlike court proceedings, inquiries are inquisitorial fact-finding exercises rather than adversarial processes.

Non-statutory inquiries

There is no legislation governing non-statutory inquiries, which have fewer powers but can operate more flexibly, with each inquiry chair being able to devise their own processes or protocols for their specific inquiry. The procedures adopted can, for example, allow for a more direct role for victims and bereaved families, depending on the approach taken by the chair. A non-statutory inquiry may also be called a review or a national audit, for example, Dame Louise Casey's recent national audit into group-based child sexual exploitation.

A non-statutory inquiry is still subject to some requirements such as the duty of candour for public authorities, fairness to witnesses and other interested persons, and the decisions of the inquiry can be judicially reviewed. A non-statutory inquiry may also have many of the features of a statutory inquiry, including hearing evidence in public.

The Public Office (Accountability) Bill, commonly known as the Hillsborough Law, is expected to introduce additional obligations on public authorities and participants, and to strengthen the framework within which non-statutory inquiries operate.

Establishing and running an inquiry

Government ministers can set up inquiries covering any issue for which they are responsible. The Government will choose a chair best suited to the inquiry. They will allow the chair to set the terms for the inquiry but may ask to be involved in that process. The minister makes a statement to Parliament or to the relevant devolved legislature formally announcing the inquiry.

Once a public inquiry has been announced, an inquiry team will be created including a secretariat, a solicitor and often legal counsel.

The inquiry will then gather information and hold evidence hearings to help form its conclusions, before producing a report to present to the minister. In statutory inquiries, the report must then be published.

Using the Southport Inquiry as an example

Catalyst

On 29th July 2024, a shocking, fatal knife attack took place at a children's summer holiday dance club in Southport, killing three girls and injuring others.

Inquiry launch

The Southport Inquiry was established by Home Secretary, Yvette Cooper, on 7th April 2025. The Chair is Sir Adrian Fulford PC, a retired Lord Justice of Appeal and former Investigatory Powers Commissioner.

Statutory status

It is a statutory inquiry with powers under the Act to compel evidence and witnesses.

Hearings

Hearings began with opening statements at Liverpool Town Hall in July 2025, followed by impact evidence from victims and families. The hearings spanned nine weeks and included evidence from over 90 witnesses across policing, criminal justice, those involved in the sale of knives, healthcare, social care and education sectors.

Phased structure

Public inquiries may be structured in phases, depending on their scope and terms of reference. In the case of the Southport Inquiry, the chair established a two-phase approach:

- **Phase 1 – Immediate circumstances and systemic failures**

Focused on establishing a detailed timeline of events and the perpetrator's history, family circumstances, and contact with public services, including policing, criminal justice, education, social care and healthcare. Phase 1 examined how agencies identified, assessed and responded to indicators of risk, including Prevent activity, mental health involvement and access to weapons.

The Phase 1 report was published in April 2026. It provided a comprehensive factual account of events and concluded that the attack was foreseeable, identifying fundamental system failings in areas such as risk ownership, information sharing and multi-agency coordination.

- **Phase 2 – Systemic and societal lessons**

Phase 2 is intended to be forward-looking and will build on the factual findings of Phase 1. The published Terms of Reference set out that the Inquiry will examine "the circumstances surrounding the attack and the events leading up to it," including the

perpetrator's interactions with a range of public bodies and systems, as well as decision-making and information-sharing across services.

The Terms of Reference state that Phase 2 will examine:

I. The adequacy of arrangements in England and Wales for managing the risk from violence fixated individuals (VFIs). VFIs are individuals at risk of extreme violence, where ideology is not the primary driver. Where arrangements are considered inadequate, the Inquiry is asked to make recommendations for improvements. In particular, the Inquiry should examine:

a. How effective are multi-agency arrangements for identifying, assessing and managing the risk posed by VFIs? This includes Prevent, Youth Offending Teams and policing.

b. How integrated are these arrangements with wider safeguarding systems, mental health services, social care and education? Could improvements be made to better identify and manage VFIs?

c. What interventions reduce the risk to the public from VFIs? What barriers exist to delivering them and how can they be overcome?

d. Do other threat management systems such as those for terrorism or organised crime have lessons for good management of VFIs?

II. The role of the internet and social media in influencing and enabling VFIs to prepare and carry out violent attacks. Proportionate to the timetable set out below, the Home Secretary would welcome expert evidence on this subject.

III. The effectiveness of current laws and systems for identifying, monitoring and disrupting the activities of VFIs online and reducing the harm caused by online spaces which promote extreme violence.

IV. The effectiveness of policies, regulation and criminal enforcement in relation to the sale and possession of offensive weapons and articles with a point or blade.

At the time of writing, Phase 2 of the Southport Inquiry is ongoing, with the aim of concluding proceedings and producing a report to the Home Secretary by May 2027.

Case study: Lancashire Safeguarding Partners' experience

In relation to the Southport Inquiry, after careful consideration, Lancashire Safeguarding Partners took the decision to pause their Local Child Safeguarding Practice Review (LCSPR) while the Inquiry progressed. This approach aimed to minimise duplication with the Inquiry process, reduce the risk of prejudicing parallel activity and lessen additional impact on families and practitioners. The position remained under regular review and was supported through ongoing engagement with the Child Safeguarding Practice Review Panel.

Throughout this period, partners maintained a clear focus on ensuring that local learning continued to be identified, shared and acted upon. An initial rapid review was undertaken to support timely system learning. Partners prioritised early reflection and collaboration, including the development of an extended multi-agency chronology and a full-day, in-person multi-agency review event.

The following practice supported the rapid review process and subsequent partnership activity:

- Multi-agency information sharing and oversight, including shared chronologies, to support early identification of learning and understanding of systemic patterns of concern.
- Coordination between Multi-Agency Safeguarding Arrangements (MASAs) where individuals had contact with services across organisational, geographical or partnership boundaries.
- Strong multi-agency leadership and governance arrangements, with shared decision-making and appropriate senior-level oversight in complex and high-profile circumstances.
- Clear communication and coordination across parallel processes, including safeguarding activity, criminal investigations, reviews and public inquiry requirements.
- Robust record-keeping practices, including the maintenance of clear and timely documentation, to support information sharing and provide an audit trail of decisions and actions.
- Recognition of workforce impact, with attention to the wellbeing of practitioners, leaders and partnership staff working under sustained pressure.

Learning has been embedded locally through a joint multi-agency action plan, agency ownership of actions, and regular senior-level oversight, enabling improvement activity to progress alongside the Inquiry, rather than being deferred until its conclusion.

Alongside this work, partners responded to significant volumes of information and evidence requests, including responding to iterative requests over time. They drew on

Legal and Information Governance expertise to support lawful, proportionate information sharing, and to address potential conflicts of interest and resource implications.

The Inquiry required a formal statement from the partnership, which was drafted on behalf of the partnership and signed collectively by the three Designated Safeguarding Partners. Throughout the process, partners sought to balance Inquiry-related demands with maintaining ongoing safeguarding activity and providing support to those affected by the incident and the sustained period of scrutiny.

Hallmarks of good practice in cases that become the subject of an inquiry

- **Map agency involvement early**
  Identify all relevant agency contact with victims (where applicable) and perpetrators, including historical involvement across policing, Prevent, health, social care, education and other services. Pay particular attention to cross-boundary and multi-agency involvement over time.
- **Continue to identify and embed learning**
  While it may be appropriate to pause an LCSPR during a public inquiry, this should not prevent partnerships from identifying early learning and acting on it. Be prepared to reflect on what could have been done differently and to test this thinking across agencies. Learning and improvement activity should continue alongside the public inquiry, rather than waiting for formal findings.
- **Secure, compile and protect evidence**
  Gather and preserve all relevant documentation, including referrals, assessments, chronologies, call logs, decision-making records and health information. Ensure records are protected from accidental deletion or inappropriate access and that information is clearly summarised to support understanding over time.
- **Plan for document disclosure**
  Organise information in searchable, well-labelled formats aligned to the inquiry's Terms of Reference. Seek early legal advice to understand disclosure requirements, thresholds for withholding information, and the management of sensitive data, including personal and third-party information.
- **Review local protocols and systems**
  Examine safeguarding arrangements, information-sharing protocols, escalation routes and relevant specialist processes (for example Prevent or weapons-related procedures).
- **Prepare core participants and contributors**
  Identify individuals and organisations likely to be core participants. Ensure appropriate legal advice, clarity about roles, and organisational support for those required to engage formally with the inquiry process.

- **Prepare and support witnesses**
  Select a corporate signatory (for a Corporate Witness Statement) who can confidently explain factual events and organisational context, noting the inquiry may also request evidence from individual witnesses. Offer wellbeing and pastoral support before, during and after evidence is given, recognising the personal and professional impact of inquiry participation.
- **Maintain leadership oversight and workforce support**
  Ensure clear senior-level leadership grip across the partnership, with shared decision-making and challenge. Recognise the sustained pressure an inquiry can place on practitioners, leaders and partnership staff, and consider proactive wellbeing and support arrangements alongside business-as-usual safeguarding activity.

Reflective questions

1. What arrangements would we need in place to support our workforce, leaders and partnership staff through a public inquiry process, and is everyone aware of their obligations under the duty of candour?
2. Are our information systems, record-keeping and governance arrangements robust enough to support large-scale evidence sharing and scrutiny?
3. How would we sustain learning and improvement activity if a local review were paused due to an inquiry?
4. What barriers might limit our ability to respond effectively (for example capacity, legal advice, information governance), and how could these be mitigated?
5. Has anyone in our partnership previously been involved in a public inquiry, and how can their experience inform our preparation?
6. How can we effectively manage multiple parallel processes?

Where can I find out more?

General information on public inquiries

- Public inquiries – Institute for Government
- Public inquiries – House of Commons Library
- Failing to follow up on public inquiry recommendations risks avoidable mistakes being repeated – UK Parliament

Legislation and guidance

- Inquiries Act 2005
- The Inquiry Rules 2006
- Child Safeguarding Practice Review Panel – GOV.UK

Selected public inquiries and reviews

- Southport Public Inquiry
- Southport Inquiry: Terms of reference – Phase 2 – Southport
- The Victoria Climbié Inquiry – Lord Laming's report
- The Statutory Independent Inquiry into Grooming Gangs
- National audit on group-based child sexual exploitation and abuse
- The Angiolini Inquiry
- The Nottingham Inquiry
- Independent Inquiry into Child Sexual Abuse (IICSA)
- UK Covid-19 Public Inquiry

Glossary of key terms

Core Participant Status

A designation under the Rules applicable to statutory inquiries for individuals or organisations with a significant interest in the inquiry. The chair may designate core participants of their own initiative or following an application. Core participants have enhanced rights, including receiving early disclosure of evidence provided by witnesses, making submissions, and suggesting lines of questioning. In non-statutory inquiries, similar roles may exist but are not governed by the Rules and may be described using different terminology.

Rule 9 requests

If a statutory inquiry wishes to take written evidence from a person or organisation, it may send a request in writing pursuant to Rule 9 of the Rules (a Rule 9 request). This may include requests for written evidence, documents or other information. An inquiry may make a further Rule 9 request for additional written or oral evidence. This is the most common way in which inquiries seek evidence initially, on a voluntary basis.

Section 21 notices

Section 21 of the Act provides the inquiry chair with power to compel a person or organisation to, within a set period, provide evidence to the inquiry, including by attending at a specified time or producing documents. The chair must give notice of this requirement and explain the consequences of not complying. Failure to comply with a Section 21 notice, without reasonable excuse, is an offence and may result in a fine or imprisonment. In most instances, an inquiry will seek evidence through a Rule 9 request before issuing a Section 21 notice.

Rule 13 – warning letters

Letters issued under Rule 13 of the Inquiry Rules to a person or organisation where the inquiry considers that it may be subject to explicit or significant criticism in the report.

These are sometimes referred to as Maxwellisation letters. Warning letters provide an opportunity to respond to potential criticism in line with principles of procedural fairness before the report is finalised and published. In some inquiries, letters may also be issued before oral evidence is heard to give individuals or organisations notice of potential criticism arising during hearings and an opportunity to respond. These are distinct from Rule 13 warning letters and are not governed by the Rules.

Restriction order (Section 19 of the Act)

An order made under Section 19 of the Act restricting public access to inquiry proceedings or limiting the disclosure or publication of evidence or other material, for example where this is required in the public interest, including to protect national security, personal privacy, or confidentiality.

Terms of reference (ToR)

The formal scope and objectives of the inquiry, setting out the issues to be examined and the boundaries of the inquiry's work.

Inquiry chair

The independent individual appointed to lead the inquiry. The chair is responsible for determining the inquiry's procedures, managing hearings, making findings, and producing the inquiry's reports.

Secretariat

The administrative and operational team supporting the inquiry, responsible for managing correspondence, evidence, hearings, records and day-to-day running of the inquiry.